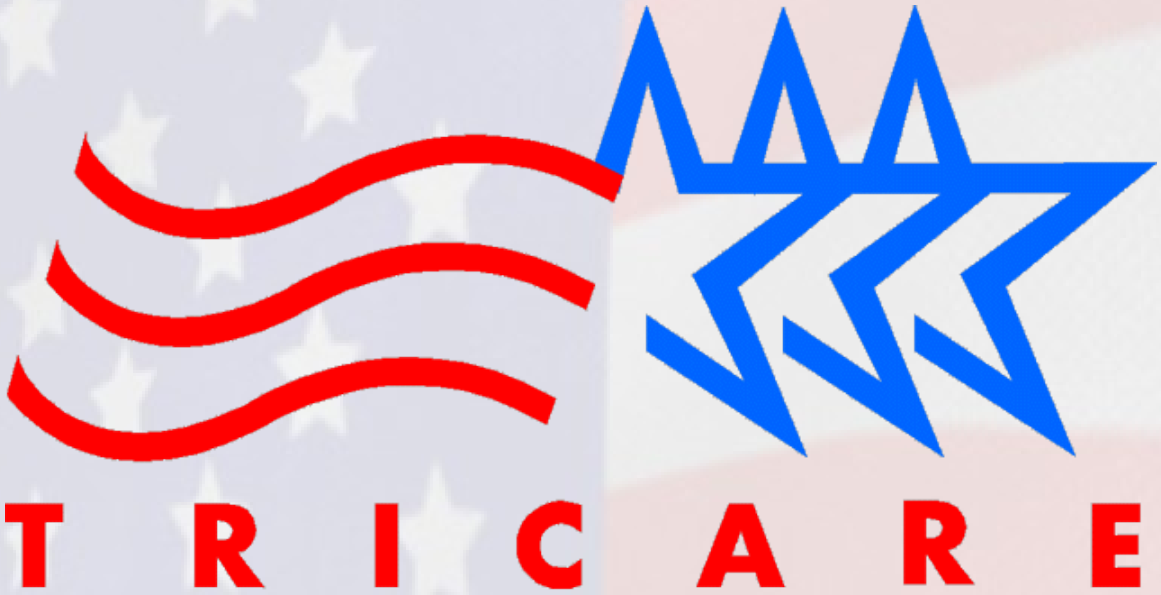

2000

“Focus on Performance”

MEPRS for Dummies

- John McQueston
- National Naval Medical Center
- JAMcQueston@bth20.med.navy.mil
- (301) 295-9273

- Jane Cunningham
- JMCunningham@usmed.navy.mil
- (202) 782-3564

Objectives

- Provide a basic understanding of the MEPRS costing system
- Enable managers to make informed decisions about
  - *the quality of cost information they wish to produce*
  - *the degree of data timeliness, completeness, and accuracy required*

Objectives (Alternative View)

- Discuss and hopefully debunk the MEPRS Urban Legends
- Develop the argument that if MEPRS didn’t exist we would want to create something much like it
- Provide a starting point for clinicians to begin a dialogue with their resource managers

Medical Expense Performance and Reporting System

- As the name implies a **Triservice** system to allocate medically related costs for **fixed** medical facilities in order to determine financial performance
- Guidance is modified yearly before the start of the next fiscal year (Happy Halloween!)
- Oversight provided by Triservice working groups

MEPRS is a Way of Modeling Data

- All data models have advantages and disadvantages
- Examples: maps versus globes, zip codes vs. street addresses
- Understanding the strengths and weaknesses is crucial to using the model appropriately (garbage in, gospel out)

Broad Functional Categories are Used for Initial Grouping

- A Inpatient
- B Outpatient
- C Dental
- D Ancillary and support
- E Support Services
- F Special Programs
- G Readiness

Categories

- Some categories are **final** (A,B,C, F and G above), while D and E categories are **intermediate** operating accounts, whose expenses are reassigned to the other categories using a procedure called **step down**.

Locations

- Functional categories are decomposed into summary and subaccounts
- EF Housekeeping
- EFA Housekeeping in house
- EFB Housekeeping contract
- EFZ Housekeeping not elsewhere classified

Or

- BH Primary Medical Care
- BHC Optometry
- BHCS Optometry Dahlgren
- BHCU Optometry Arlex

Subaccounts

- Subaccounts are identified by a group of 4 letters
- First letter functional category
- Second letter summary account
- Third letter subaccount
- Fourth *alphanumeric* (not standardized) usually employed to differentiate functional areas with different locations e.g. Family Practice North, Family Practice South, but can also describe a subfunction- Same day surgery, Observation, Hospice

Next

- After locations are assigned a MEPRS code the fun begins: data on inputs and outputs is collected and aggregated by location.
- In order to determine the ratio between inputs and ouputs both must be collected with comparable accuracy.

Examples of inputs

- Salary costs
  - *Military Labor*
    - Borrowed
    - Loaned
  - *Civilian Labor*
- Supply costs
  - *consumables*
  - *equipment*
- Overhead costs
  - *Facility Repairs*
  - *GME training*
  - *TAD*
- Readiness costs
  - *Labor*
  - *Training*

Examples of Outputs (Performance Factors)

- occupied beddays
- visits (very specific MEPRS definition)
- occasion of service
- weighted procedure (lab,rad and pharm)
- EKGs
- Laundry Washed (pounds)
- Ambulance hours of service
- Minutes of service

Step Down

- Step down- the process of reassigning or allocation of expenses from ancillary and support accounts (D and E MEPRS codes) to the benefitting work centers.
- Expenses are allocated proportionate to workload
- e.g. radiology expenses are stepped down to clinical centers based on workload units
- Simply put- the expenses are spread- like peanut butter

After costs and workload (Outputs) have been collected final operating costs are calculated.

- This may or may not be appropriate for the analysis being conducted. If a clinical unit is downsized or outsourced the overhead costs may or may not go away (e.g. hospital administration) and will be spread (like the proverbial peanut butter) to the remaining acccounts- driving unit costs up.
- Likewise shedding administrative costs (e.g. forced cut in IM/IT) will make cost per workload unit less.

First

- Step down is performed, E codes first, thus the cost of housekeeping is spread to the final accounts as well as to the ancillary services accounts. This can be seen in the examples above.
- The cost of optometry includes the some costs for housekeeping but the cost of housekeeping does not include some cost for optometry.
- Cost form the D codes are then redistributed to the final accounts.

Question

- What are some of the cost elements are included in the calculation of the cost of an average occupied bedday for the Pediatric Service ?

Answer

- Nurse staffing
- Clinician staffing
- Supply costs
- Portion of E and D costs

Question

- A new pediatrician reports aboard to the command. During the 50 hours she is at work she spends 5 hours in morning report, 4 days in clinic 009-1200 and 1300-1600, goes to 3 committee meetings (1 hour each) spends one day covering the nursery (10 hours) and spends Saturday (8 hours) performing a JAGMAN investigation on a death which occurred at another hospital. How should her time be reported?

Answer:

- Morning Report is charged to the workcenter where that individual is assigned i.e. BDAA (Pediatrics), or BHAA (Primary Care at MFHC)
- Clinic time is assigned in the same way.
- Command Committees are assigned to EB (Command Management and Administration)
- Nursery Time is A (Inpatient) either ADB (Newborn Nursery), or AGH (Family Practice Newborn Nursery). As you can see there is no Primary Care code for Nursery. *It is up to commands to ensure the available codes are assigned in a way that is internally consistent and not just use codes because they are available*.
- Jagman Investigation is FCD (Support to Other Military Activities)

Question:

- Why does the command only report 42 hours of work for this clinician when she really worked 50?

Answer

- MEPRS takes annual salary costs and converts it to an hourly rate by using a fixed conversion factor (42 hours/week). If more than 42 hours is reported the MEPRS model would calculate the costs as if the clinician was being paid overtime (which isn't the case)
- All models have limitations- this is a limitation in the MEPRS model

Note

- In the example above only 62% of this clinician's salary costs should be attributed to running the Pediatric Clinic. If however, she does not correctly fill out her time sheet and just indicates a full work week in the Peds clinic, she will increase the calculated cost of running the clinic, and decrease the cost of running the nursery. Mistakes like these have caused central planners to erroneously target hospitals for closure or downsizing.

Question

- How are the costs of running the laboratory, radiology and pharmacy reassigned to the clinics requesting those services?

Answer

- A relative workload value for each service provided is assigned. Workload values are summed and a cost per workload unit is determined. Each MEPRS location is then assigned a fraction of the total cost for each of these ancillary services based on the number of workload units requested. Thus if the clinic requested 10% of the radiology relative weighted product, 10% of the radiology cost will be attributed to the cost of operating that clinic.

Things that MEPRS doesn't do:

- Remember what the "P" in MEPRS stands for. MEPRS is designed to provide information on relative **financial performance** within or between MTFs.

Things that MEPRS doesn't do:

- It is **not** a billing system. It does not determine whether services rendered need to be reimbursed by a third party. Financial transfers between government agencies are usually arranged by an MOU or a resource support agreement.

Things that MEPRS doesn't do:

- It is **not** a human resource system. Military billets are determined by platform requirements and skill mix, and the need for additional human resources is determined by many factors including changes in the beneficiary population, anticipated need for clinical services and the availability and cost of services in the community.

Double Counting Workload:

- Example: A Navy provider takes call at an Air Force MTF. While he is there he sees 10 Navy patients. How should his time be reported? Which MEPRS location should be credited with the 10 visits?

Answer:

- The provider should report his time under an “E” code as support to another military activity.
- The visits must be reported at the Air Force MTF, after all the MTF provided the physical space, heat, light, pharmacy, etc.
- The fact that the patients are Navy is irrelevant for MEPRS purposes in this situation.
- In order for Navy and Air Force to feel secure about this arrangement, an MOU should be executed which outlines the rights and benefits of both parties. In any case, these 10 visits can **not** be counted at the naval facility where the Navy doctor is assigned.

What about two workcenters within NNMC?

- Suppose an internist, a dermatologist and a surgeon form a primary care team. Down the hall an obstetrician and a pediatrician form a different team. Each work center has shared expenses and staff, and reports workload as visits. How should their MEPRs be reported.

Answer

- This is a common cause for confusion and disagreement. The original model used nomenclature that was based on medical specialties. Thus, there is a tendency to split each group into tiny segments. However, the key concept is workcenter. If they really share resources and equipment it is too confusing to try to split it out. Thus the best solution is two primary care workcenters, different at the fourth level.

What about a satellite clinic?

- A psychiatrist brings his team to a branch clinic once a week. They travel in a POV and are reimbursed. They provide the same level of care as in the psychiatry clinic at the main MTF.
- How should this be reported?

Answer

- Here the best solution is to have a psych clinic at the branch clinic BFAA. The travel expenses are also allocated to this center and the work load is visits. Floor space will need to be prorated from the branch clinic.

More information

- MEPRS page at NMIMC
- http://imcenter.med.navy.mil/meprs/Default.htm
- http://www.meprs.amedd.army.mil/

DEPARTMENT OF DEFENSE

TRICARE

Your Military Health Benefit

PRIME
EXTRA
STANDARD

TRICARE
www.tricare.osd.mil

World Class Health Care
for the World's Best Military